CONSULTATION DRAFT JULY 2012

GLASGOW CITY JOINT ADULT SERVICES PLAN 2012/13

Alcohol and Drugs • Mental Health • Homelessness • Adults with Disabilities • Older People

Our Vision

A model of health and social care that improves the outcomes of Vulnerable Adults and Older People, through the key objectives of:

- ***Early prevention and harm reduction***
- ***Providing greater self-determination and choice***
- ***Shifting the balance of care***
- ***Enabling independent living for longer***
- ***Quality Care Management***

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Foreword

We are pleased to present the new Joint Adult Services Plan for Glasgow City. This Plan sets out the joint vision, objectives and priorities for change in the delivery of care and support services in order to address the needs and aspirations of vulnerable adults and older people in the City.

Community health and social care can only work effectively through partnership – between the statutory agencies, and with independent sector providers, service users and carers. The Joint Adult Services Plan 2012/13 expresses that commitment to partnership working on behalf of Glasgow City Council and NHS Greater Glasgow and Clyde. It is a commitment that will be further tested over the next few years by finite resources, ongoing health and social challenges in the population, and ever increasing demand for person-centred high quality services.

However, we believe that the foundations are in place in Glasgow to meet these challenges. We are committed to delivering the strategic objectives set out in this Plan in order to improve the effectiveness of services and ensure better outcomes for our service users, carers and communities. We are determined to further develop and implement a range of integrated care and support services that intervene early where risk is identified, enable people to remain in their local community, promote independence, and offer personal choice appropriate to an individual's needs. This Plan sets out how we will continue to improve the lives of those who need our care and support.

The Purpose of the Plan

The Joint Adult Services Plan is intended as a reference point for all staff, service users, carers and members of the public as it outlines current developments across service provision in Glasgow. This Plan:

- Sets out the overall vision for adult and older people's services in Glasgow.
- Highlights the health and social characteristics of the population we serve.
- Reflects on key achievements to date.
- Outlines the future policy direction for the delivery of care and support services in Glasgow.
- Summarises specific objectives and priorities for the next year and beyond.
- Sets out the key targets for 2012/13.

In addition, the Plan identifies the major areas of service reform taking place, including:

- The roll-out of personalised services across Learning Disability, Physical Disability and Mental Health Services.
- The integration of community-based services for Older People through the *Reshaping Care* initiative.
- The implementation of a Joint Housing Options Pilot offering a comprehensive range of information, advice and support services to people who are homeless or potentially homeless.
- The reconfiguration of Alcohol and Drug services to enhance treatment and recovery in the community.
- The provision of suitable accommodation, both for individuals and for projects supported by health and social care budgets, which will also support the delivery of the Glasgow Housing Strategy.

The Plan has been developed and produced in consultation with key stakeholders, including Council and NHS staff, independent care providers, housing providers, and service users and carers. An Annual Review will be produced next year to report on progress made and to chart further activity.

The Glasgow Context

The following population, health and social care facts illustrate the challenge facing the Council and Health Board over the next year and beyond:

- Glasgow has a current population of 592,820, accounting for just over 11 per cent of the Scottish population. Although the population declined sharply through the latter part of the 20th Century, it has been increasing again since 2004. It is predicted to increase to 599,870 by 2018.

- In terms of age structure, the proportion of adults (aged between 20 and 44) among the population is set to increase until 2028 (by 3.3 per cent), bucking the national trend (a decline of 2.6 per cent). The proportion of people aged 65 or more is expected to remain stable, although increases are likely at the very high ages (85 and above).

- It is estimated that just over 11 per cent of Glasgow's population is of a BME background or non-British White background.

- According to the Scottish Index of Multiple Deprivation, Glasgow City contains:
    - 13 of the 20 most deprived neighbourhoods in Scotland;
    - 31% of all income deprived neighbourhoods;
    - 30% of all employment deprived areas;
    - 33% of all health deprived neighbourhoods; and,
    - 28% of all education deprived neighbourhoods.

- Although increasing, life expectancy at birth is currently 71.6 years for males and 78 years for females (compared to the Scottish averages of 75.8 and 80.4).

- Almost 20,000 people (3.3% of the population) were estimated to have a learning disability in 2009.

- Almost 100,000 people (16.8% of the population) are estimated to have a physical disability.

- Almost 82,000 people were recorded as having a hearing impairment and almost 8,000 people were recorded as having visual impairment in 2009.

- It is estimated that up to 7,000 people in Glasgow have a form of autism.

- According to national estimates, around one in 25 people will be experiencing dementia by their seventies, up to almost one in five by their eighties. Therefore up to 4,500 people aged over 80 in Glasgow may be experiencing dementia.

- There were just over 26,000 emergency hospital admissions for older people aged 65+ recorded for 2010.

- According to the last Census, one in ten people in the City were carrying out unpaid caring duties.

- 197 alcohol related deaths were recorded in Glasgow in 2009, around one-sixth of Scotland's total. There were over 7,600 emergency admissions to Glasgow hospitals with an alcohol related diagnosis in the same year. There were also over 8,000 hospital discharges associated with the same diagnosis in the same period, accounting for one-fifth of the Scottish total.

- 135 drug related deaths were recorded in Glasgow in 2009**,** making up a quarter of Scotland's total. There were over a thousand hospital emergency admissions with a diagnosis of drug misuse in the same year, and a similar number of inpatient discharges with the same diagnosis, accounting for one-fifth of the Scottish total.

- In 2011/12, 9,145 households presented as homeless in Glasgow, a reduction of 12% from 10,422 in 2010/11. Overall, the city still receives a higher share of national homeless applications than population share. Around 23% of applicants were assessed as having one or more support need, the main needs being identified as drug or alcohol dependency, mental health issues, and need for basic independent living skills.

- In 2011, 25,455 people applied for asylum in the UK. Of this, just under 10% are in Scotland. Notable countries of origin include Iran, Pakistan, Afghanistan and Eritrea. At the end of 2011, there were 2,066 people seeking asylum being accommodated in Glasgow whilst their claim is being assessed. Just over 500 main applicants, along with their dependants, were granted Leave to Remain in 2011.

- There were 2,760 admissions to specialist Mental Health Hospitals in Glasgow during 2010/11, accounting for 13 per cent of the Scottish total.

Shaping the Future

Introduction

As the previous section highlights, there are significant and ongoing health and social care challenges in the City, underpinned by high levels of neighbourhood deprivation. Furthermore, the current economic climate will not only restrict the expenditure available to provide services to meet the already sizeable existing need, but may increase the demand for health and social care services in the City at the same time.

Impact of the Economic Downturn

In the current economic downturn, the Council, NHS Board and their key partners must embrace change as the route to meeting needs and delivering the shared vision for services for vulnerable adults and older people. We will continue to invest in community-based health and social care, but invest to create a *different model of care,* one that is workable, sustainable and co-produced with Glasgow's citizens.

We will do this by establishing the outcomes that our service users, carers and communities need and want to achieve, and configure our services and funding arrangements in ways that we think will best facilitate these outcomes.

Impact of Welfare Reform

The impact of welfare reform also has the potential to be significant in Glasgow. Glasgow has a high number of recipients of welfare benefits. Reductions in benefits to residents*,* issues around Direct Payments and potentially increased arrears, will reduce the Council's income. A number of the key potential issues for Glasgow are outlined below:

- Local Housing Allowance has been reduced for private sector tenants, and people under 35 are now only eligible for the shared room rate, making a private sector tenancy less affordable for younger people and larger families, and placing further demand pressure on the social rented sector.
- From April 2013, Housing Benefit provision for social sector tenants will be restricted to match family size, not accommodation size, increasing demand for transfer moves to smaller properties from households currently under occupying, potentially reducing availability for lets to homeless households.
- Universal Credit will be phased in from October 2013, with payments being made directly to applicants, potentially increasing rent arrears and evictions, and placing more pressure on homelessness services.
- Councils, such as Glasgow, which have transferred housing stock to the Housing Association sector, will face particular difficulties in continuing to fund supported, temporary and emergency accommodation with reductions in housing allowances, whilst facing more demand for such services.
- Glasgow uses its full allocation of Discretionary Housing Payment, and the additional funds offered will make little impact given the size of the losses.
- Reductions to Disability Living Allowance may have a significant impact on the council's non residential care charging policy.

- The ongoing re-assessment process for people receiving Incapacity Benefit is likely to result in a significant proportion of people moving off health related benefits onto Jobseekers Allowance. This will result in reduced income levels, as well as exposure to mandatory employment programmes, which bring with it the potential for benefit sanctions in the event of non-compliance.

Organisational Impacts
Within Social Work Services, there has been a significant reduction in the number of FTE staff since 2007/8 - a reduction of over 25%. However, during the same period, the number of individuals receiving community care, children and families, and alcohol and drug services, has remained very stable, never falling below 50,000.

Both the Council and the NHS Board have also had to review how they work and where they work. For example, the Councils Tomorrow's Office programme is delivering an office rationalisation programme that will contribute to both operational and energy efficiency while creating more flexible, modern working environments for staff.

Integrated Resource Framework
Future joint resources may be allocated via the Integrated Resource Framework, which is being developed jointly by the Scottish Government, NHS Scotland and COSLA. This will enable partners in NHS Scotland and Local Authorities to be clearer about the cost and quality implications of local decision-making about health and social care. The Integrated Resource Framework helps partnerships to understand more clearly current resource use across health and social care, enabling better local understanding of costs, activity and variation across service planning and provision for different population groups. Current pilots are underway across Tayside, Ayrshire and in Lothian and Highland authorities.

One Glasgow
Much of this agenda aligns with the parallel reform taking place within the Scottish Public sector about a "*Total Place*" approach to budget planning and financial challenges. Core partners have established the *One Glasgow* process to review, demonstrate and recommend how positive outcomes can be maintained or improved in the City with fewer combined resources. One Glasgow essentially focuses on specific shared priorities, eliminating duplication, and creating efficiencies.

Both Greater Glasgow and Clyde NHS and Glasgow City Council partners manage significant financial and other resources in Glasgow. As an indicator of this:

- The City Council manages a budget of around £2.5bn.
- NHSGG&C manages a budget of approximately of £1.8bn revenue and £98m capital (for the whole Health Board area 2009-10).

Our joint commissioning activity (noted later) will also allow us to make a substantial contribution to the development of the "*Total Place*" approach in Glasgow.

Glasgow's Housing Strategy 2011/12 to 2015/16

The Council has published the housing strategy for the city, outlining the proposed outcomes and improvements to be taken forward over the next five years. This includes a range of actions which have been agreed with Social Work Services in areas including adaptations, the provision of accessible housing, the future use of sheltered housing, emerging housing needs (such as for people with Autism Spectrum Disorder), and single homeless people with disabilities linked to issues such as addictions. In addition to working with Development and Regeneration Services to monitor progress towards achievement of these actions, Social Work Services will continue to develop dialogue with Housing Organisations and representative agencies to clarify areas of common concern and examine how existing resources can be used better to achieve better outcomes for our shared service users.

Integration of Health and Social Work Services

Greater integration has been proposed by the Scottish Government as a means of improving the quality and consistency of care for older people. A government consultation was launched in May 2012 setting out policy proposals to look at greater integration between Health Boards and Social Work departments with a view towards legislative change in 2014. The implications for both organisations and their partners are significant, and it will be important to confirm if the focus of integration is just around Older People, or if wider Adult Services are in scope. It will also be important to get a sense of the high level outcomes the proposed integration seeks to achieve and whether this coheres with our local outcomes framework (see Diagram 1).

Joint Service Commissioning

The role of commissioning in the delivery of community care services is becoming ever more important. The shift in emphasis towards personalisation and choice (highlighted below) cannot be delivered without further engagement with, and development of, flexible and diverse care markets. At the same time, both the Council and the NHS Board need to ensure that they balance value for money with service effectiveness and quality as they manage their joint expenditure on commissioned care and support services for adults and older people.

In this context, the partner organisations are developing joint commissioning strategies for Older People, Learning and Physical Disability, and Mental Health, which take into account opportunities for addressing gaps in service provision, personalisation of services, disinvestment in traditional forms of hospital/residential provision and subsequent re -investment in more flexible and diverse community based services.

Reshaping Care Change Fund

The development of a Joint Commissioning Strategy for Older People's Services is a specific requirement of the Scottish Government's *Reshaping Care* initiative that has provided a Change Fund to support the development of innovative outcomes-focused services for older people in the City. The work planned over the next few years is designed to create a single unified system of health and social care for older people in Glasgow which optimises our current resources, improves connectivity,

and delivers a significant shift in the balance of care. By 2015, it is anticipated that this will result in:

- further reductions in bed days lost to delayed discharge
- reductions in hospital lengths of stay
- increases in numbers of older people supported to live and die in their own homes
- increases in the number of older people receiving reablement services
- reductions in long term care home placements
- increased application of assistive technology
- increased support to carers, including assessment of their needs
- diversification of provision in the care sector, related to the application of Self Directed Support where appropriate
- development of alternatives to long term home care.

The Joint Health and Social Work Assessment At Home Working Group are tasked with reviewing current discharge processes, guidance and procedures, in order to work towards a phased reduction in bed days. This group will also work to develop a clear patient pathway to discharge, that allows Health and Social Care professionals to co-ordinate their activities better to achieve more successful patient outcomes.

Personalisation and Reablement

Personalisation is a key driver in the shaping of social care provision in Scotland. Changing Lives, the report of the 21st Century Review of Social Work Services in Scotland, highlights how personalisation - designing and delivering support and services around the needs of individuals, their carers and communities – is a foundation of good social care practice and a key goal of social care in Scotland.

In Glasgow, demand for services is increasing across Social Work's spectrum of activity. Added to this, service users and carers have growing expectations about the quality of support available to them.

The concept of 'self-directed support' is particularly relevant to the delivery of community care services in Glasgow as it provides the opportunity to empower individuals and put the principles of independent living and personalisation of care into practice. Self-directed support can enable individuals to direct the care or support they need to live more independently at home.

The Council's Executive Committee approved the phased roll-out of Self Directed Support across Social Work Services in October 2010. As a specific mechanism for the personalisation of social care, its introduction is an unprecedented shift in policy, firmly positioning SDS as the default service delivery option from now on. The main benefits of the personalisation approach are as follows:

- it can help focus on prevention and reablement (see below), reducing both the emotional and financial costs associated with crisis intervention and intensive support

- it devolves more control to individuals and communities and enables people to become participants in their own care, rather than simply passive recipients of care

- it allows us greater opportunity to deliver services that meet the *self-determined outcomes* of individuals compared with traditional models of service provision.

Self Directed Support has already been introduced in Learning Disability and Adults with Disabilities and is now being extended to Mental Health services. The successful implementation of this service reform is the single biggest opportunity for reshaping statutory social care arrangements in the city to date, from both a provider and recipient perspective.

Reablement is a new partnership service that provides tailored support to people in their own home for up to six weeks. Initially aimed at people coming out of hospital, it builds confidence by helping people to regain skills to do what they can and want to do for themselves at home. The ethos of reablement ensures service users and carers are active participants in care, which:

- is flexible and service user-centred
- is personalised and supported by specialist staff teams
- identifies and responds early to barriers to community living

The new service began as a pilot for older people in the North East of the City and is being rolled out across the city and across care groups until March 2015.

Local Authority Care for Older People
The Council has undertaken to design and build 5 new Care Homes and 4 Day Care Centres spread geographically across the city. Each of the Care Homes will provide 120 places, and the Day Centres will have up to 30 places. The design of the Care Homes should provide for rooms for residents that can both cater for all levels of dependency and allows the resident their own space and privacy (e.g. to receive visitors) within small group living. The building itself should be of a high standard and environmentally sustainable. It is anticipated that all 5 Care Homes and 4 Day Care Centres will be delivered by early 2015.

Rehabilitation
Over the last year, Glasgow City NHS Community Health Partnership has introduced a new model of rehabilitation service aimed at offering a more integrated service to meet the health and care needs of all older people and adults with a physical disability. The overall aim of the service is to enable people to maximise their health and gain independence through a coordinated approach by all partners. More specifically, it will support discharge assessment in hospitals and provide short-term intensive rehabilitation in the community, ensuring:

- there is a single point of access to the rehabilitation service
- patients are seen by the right person at the right time with the right skills
- streamlined transitions and the removal of barriers across services and organisations

- the service supports self management through health improvement and health promotion
- the development of proactive vocational rehabilitation in partnership with a range of other services.

Prevention and Recovery
The focus on prevention as an outcome across care groups supports the need to avoid repeated "crisis" interventions in care assessment and planning, and potentially frees up resources to support more effective service user outcomes.

An emphasis on recovery also helps people achieve a sustained positive outcome, reduces alcohol and drug misuse and builds stronger, healthier, and more prosperous families and communities.

Better, early engagement with vulnerable and 'at risk' individuals will be crucial to delivering this, such as the continuation of the Scottish Government funded 'Keep Well' programme that aims to improve health as well as making a positive impact on reducing health inequalities. 'Keep Well' offers targeted health checks and anticipatory care to adults aged 40-64 years living in deprived communities and currently covers 77 general practices across the City.

Glasgow City has one of the highest rates of suicide in Scotland, particularly concentrated in areas of multiple deprivation. Glasgow City Choose Life Strategy Group was re-established in September 2011, to respond to the refreshed national strategy through the development of a new city wide multi agency action plan, including addressing suicide prevention activity for vulnerable groups and addressing the suicide prevention training needs of key groups of staff.

Homelessness Prevention and Tenancy Sustainment
The Scottish Government has established five regional hubs, involving all 32 Local Authorities, to promote a Housing Options approach to homelessness prevention. The aim is to refocus resources from a traditional homelessness assessment and casework method, to provision of a more holistic service intended to help sustain people in their own homes, or to investigate a broader range of rehousing options and make better use of both public and private sector resources. Early intervention and strong partnership working are key to the success of this approach, and the Council has established a working group involving a range of partners to take forward local implementation.

The homelessness prevention agenda is strongly supported by the work of Essential Connections and Vulnerable Housing Forums, led by Health, and involving housing providers, service providers and the voluntary sector.

Homelessness and Asylum
Glasgow's Housing Strategy 2011/12 to 2015/16 notes that the city is likely to continue to receive in-migration as a result of international mobility and that there is a need to continue to re-examine housing equality issues for new migrants as well as established minority communities. Glasgow City Council no longer has the contract to accommodate and support dispersed asylum seekers from UK Border Authority (UKBA). However, the Council will continue to provide a homeless casework service

to refugees who have been granted Leave To Remain under legacy and the New Asylum Model. The newly formed Asylum and Refugee Services created through a merger of the former Glasgow Asylum Seekers Support and Refugee Support Teams will carry out this work. The Council will continue to work with the Scottish Refugee Council and other partners to identify the implications of the recent renegotiation of the contract for accommodation by UKBA, and to continue to develop a joint approach to good practice.

Social Care Direct

Social Care Direct is the proposed centralised, single point of contact, operating model agreed as part of Social Work's 2010/11 Budget and Service Plan. Jointly managed between Social Work Services and Customer and Business Services, Social Care Direct will be applied to specific areas of Adult Services from 2012 onwards in order to:

- Achieve a reduction in specialist Social Work resources fulfilling 'commodity' customer contact activities.
- Enable the release of existing specialist Social Work resources to address existing resource gaps.
- Implement a more streamlined efficient contact model.
- Improve public access to our services.
- Improve the initial contact the public has with Social Work.
- Improve consistency across local areas and standardisation of the service the public will receive.
- Achieve centralised visibility/management of information to enable improved planning and case management.

Ongoing Commitment to Employability

Health and Social Work continue to work to ensure that mainstream and specialist employability services meet the needs of service users. Services will work to increase the number of service users accessing employability support as appropriate and ultimately moving into employment, maximising the range of employment opportunities linked to the Commonwealth Games in 2014 as well as supporting service users to access the volunteering opportunities, which will be available.

Employability promotes full participation in society, can reduce poverty and improve the quality of life and wellbeing of our service users. These issues are particularly acute in Scotland where the jobless rate increased overall by 20,000 in the quarter to December 2011, and the current rate of unemployment is just above the UK average at 8.6%[1]

Service User and Carer Engagement

The views of service users and their carers are critical in shaping our responses to all of the opportunities and challenges facing us. For example, the views of older

[1] UK rate reported by ONS at 8.4%, February 2012

people and their carers are sought by partners in a number of ways on an ongoing basis and will have a key role in informing the development of a Joint Strategy for Older People in Glasgow as well as the Direct Services evaluation of existing Local Authority Residential Care.

National and local evidence to date suggests that in addition to appropriate housing and being able to easily access quality health and social care services when required, older people want and value low level practical help and emotional support that can make a real difference to their lives in their homes and communities.

This could include a range of low level, preventative services, such as housing aids and adaptations; help with jobs around the house; gardening; help with paying bills; accessible transport; assistance to go shopping or to attend other outside engagements; support for informal carers; befriending and opportunities for social interactions.

These types of preventative services can have significant benefits in terms of the health, wellbeing and quality of life of older people who access them and their carers. In addition, evidence also suggests that they can reduce older people's reliance upon and use of formal services and more institutional forms of support.

The Carers Planning and Implementation Group is in the process of establishing a Carers Reference Group as an integral part of the carer planning structures within the city, which will regularly update on progress to the Reshaping Care Strategy Group. The reference group is intended to be representative of the various carer groups/organisations within the city, including those advocating for and supporting older people. Plans include events within each of the three sectors to develop local reference groups, which are due to be in place by Summer 2012. Partners are committed to ensuring that representatives from voluntary sector carer organisations will continue to contribute to carer strategic planning processes, and use their expertise to work in partnership with all stakeholders to improve delivery of carers' services in the city.

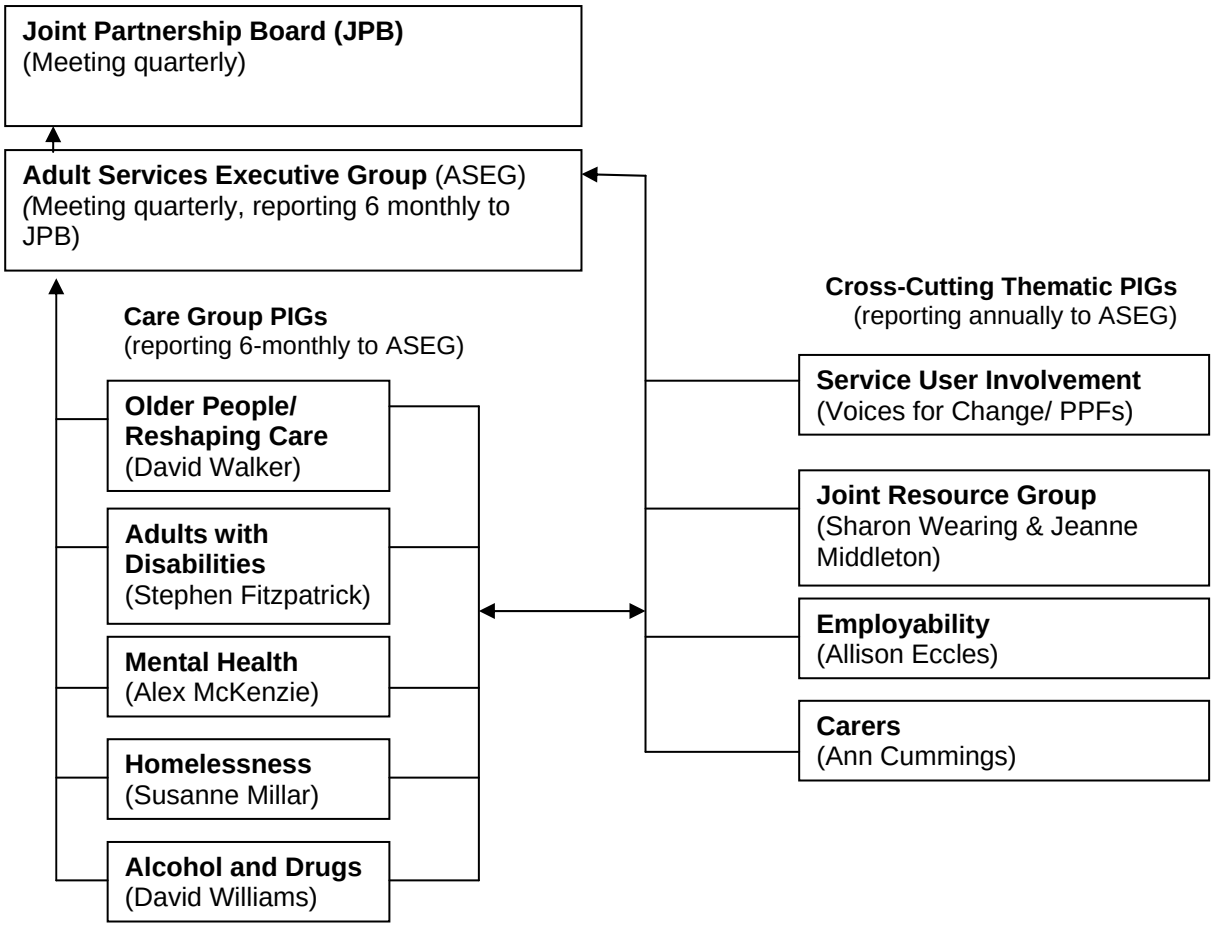
Elsewhere, the Alcohol and Drug Partnership has consulted extensively with all partners throughout the creation of the Strategy document and subsequent action plan. Please refer to the published document: "Glasgow City Alcohol and Drug partnership Strategy - Consultation Feedback 2011"

Currently, Homelessness Services is undertaking a comprehensive service user profile exercise to determine the extent and scale of service user need and demand. As part of the Housing Options Pilot in 2012, Homelessness Services, working with Glasgow Housing Association, Glasgow Homelessness Network and Shelter, will undertake ongoing evaluation, including input from service users, to help improve service provision.

The Structure of Partnership Working

As can be seen, the Council and NHS Greater Glasgow and Clyde, as Community Planning partners, remain committed to jointly developing and improving health and social care services to support Glasgow's citizens more effectively, more efficiently and with a better focus on positive outcomes. As a result, the Council's Social Work

Services and the NHS Board have implemented new joint governance and planning structures to underpin the ongoing delivery of relevant, seamless services to the people in our communities who need them. This structure is set out below.



The **Joint Partnership Board**, consisting of elected members and non-executive NHS Board members, will perform the role of monitoring performance and budgets, and oversee service planning processes for joint adult services in the City. This Board undertakes the same role for joint children's services in the city. As a result, the Board has summarised its aspirations and strategic focus for integrated health and social care services for the adult population in the following Vision Statement:

"A model of health and social care that improves the outcomes of Vulnerable Adults and Older People"

The **Adult Services Executive Group** oversees the development of city-wide joint planning for adult services and reports to the Joint Partnership Board on progress against agreed priorities, guides the development of annual work plans for each care group, and monitors the performance of these work plans. Membership includes the Glasgow NHS Community Health Partnership Director, the GCC Executive Director for Social Care and relevant Senior Management and Finance leads from both parent organisations.

Sitting below the Executive Group are five **Care Group Planning and Implementation Groups** – Older People, Adults with Disabilities, Homelessness, Alcohol and Drugs, and Mental Health. The role of these groups is to serve as the primary strategic planning function for the relevant care group, by developing joint strategic priorities and activities that will support the delivery of common strategic objectives and outcomes for adult services in the city. Each will report to the Adult Services Executive Group on progress and performance at regular intervals. All groups have membership from a range of other organisations, including other statutory partners, independent care providers, housing and voluntary sectors, and service user and carer representatives. The agenda for each group will include consideration of housing and supported accommodation issues relevant to service users and carers.

The influence of service users and carers on future service planning is further enhanced by the formal involvement of the City-wide Voices for Change forum within the joint adult services planning structure. This group, funded by Social Work Services, is representative of all five care groups and has direct access to the Executive Director, Social care. Furthermore, consultation and engagement around service reform will also continue via local NHS Public Partnership Forums.

The planning structure also currently features two thematic planning groups – for Carers and Employment – that will support the Care Group Planning and Implementation Groups to take forward these important cross-cutting agendas within adult care. Finally, the Joint Resources Group will play a crucial role in monitoring the joint financial frameworks for each of the planning groups, produce joint budget monitoring reports to highlight pressure areas, and ensure that appropriate resources are being redirected to deliver service priorities. It will also play an important role in assessing and monitoring the impacts of the economic climate and welfare reform on behalf of the planning groups.

We are confident that this new governance and planning structure will provide the appropriate framework within which all key stakeholders can pursue joint objectives and outcomes for adult services in Glasgow.

Outcomes Framework for Adult Citizens

Diagram 1 sets out the joint vision of adult services in the City, the specific outcomes that we want to support service users and carers to achieve, and the key objectives that we have set for our services in order to support the delivery of these outcomes. The five related objectives provide more insight into to the strategic direction of travel we will take in joint service provision. The five outcomes that we wish to support service users and carers to achieve are drawn from the national ‘Talking Points’ outcomes agenda for community care and these are:

Vulnerable adults and older people:

- feel physically and emotionally safe
- are involved in decisions about their care
- are engaged in community leisure and social activities of their choice

- are engaged in development opportunities of their choice (including employment, education, training or volunteering).

Carers:

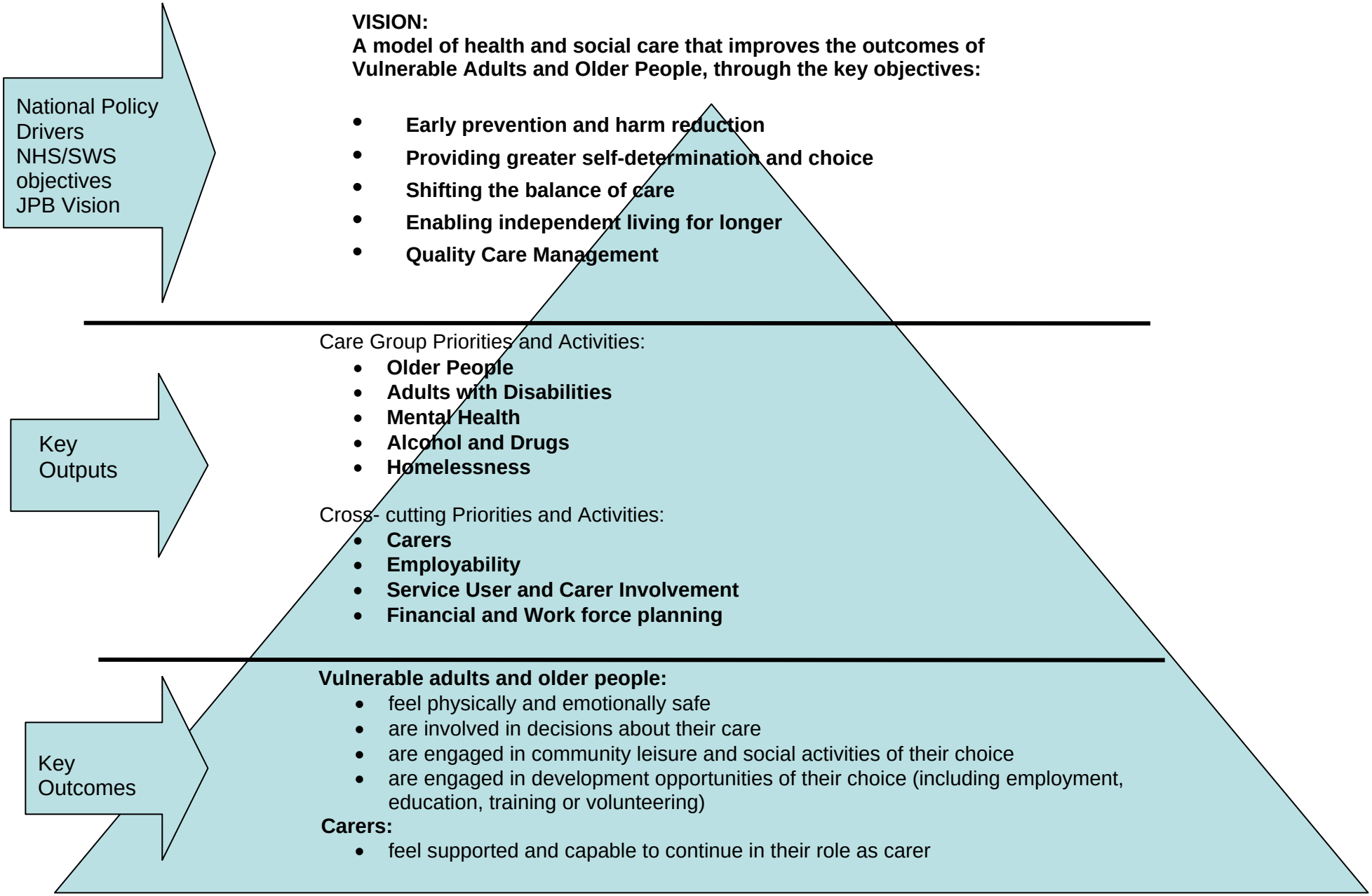
- feel supported and capable to continue in their role as carer

We believe this model provides an accessible outline of what all stakeholders are collectively trying to achieve, provides a common framework for each Planning Group to identify the objectives and outcomes that they will support to deliver via their ongoing activities, and will provide the Joint Partnership Board with a tool to monitor progress and performance.

As a result of the adoption of the **Outcomes Framework**, this Plan departs from the traditional 'Care Group' structure of the former Joint Community Care Plan. Instead it is structured by the five common objectives for Adult Services in the City as follows:

- *Early prevention and harm reduction*
- *Providing greater self-determination and choice*
- *Shifting the balance of care*
- *Enabling independent living for longer*
- *Quality Care Management.*

Diagram 1: Outcomes Framework for Adult Citizens



Key Achievements 2011/12

The last year has seen significant progress across most of our health and social care service provision across the City. The following summarises the key achievements by care group or service type in the past year:

Alcohol and Drugs

Promoting Recovery: The Alcohol and Drug Partnership has been driving the recovery agenda across Glasgow, ensuring services are offering integrated treatment, rehabilitation and recovery. There are strong links to training, employment and social reintegration. Over 90% of new referrals have a recovery plan and services are exceeding national waiting time targets. The Partnership is also an active supporter of family involvement and community engagement in the recovery process.

Inclusion: The Alcohol and Drug Partnership has a strategic vision with a range of contributions from statutory services, the voluntary sector and with recovery communities themselves. This has been successfully evidenced, through the work of the community sub-group and the success of the GRAND programme of events (Getting Real About Alcohol N Drugs) along with community consultations and conversation cafes. The City centre SOS bus, an emergency bus where revellers can go for help if they can't get home, demonstrates what is possible when partner agencies work towards a common purpose. Strathclyde Police's medically-equipped SOS bus is staffed by Red Cross volunteers who help people stuck in town because they are drunk, injured, have been assaulted, are fleeing domestic abuse or are distressed.

Equalities: The Alcohol and Drug Partnership understands the role equalities have in prevention and positive recovery, ensuring provision reflects the needs to ensure all services are person centred and takes account of age, gender, race, religion, disability or any other protected characteristic. This has been demonstrated with 95% of all new recovery plans recording protected characteristics (age, gender, ethnicity). Equality Impact Assessments are central to all service developments.

Long Term Conditions

A unique Council service that is supporting thousands of the city's most vulnerable people through serious ill health received a major national award in March 2012. The Long Term Conditions Financial Inclusion Partnership, led by a team in Financial Services, was named winner of the Health and Social Care category at the Local Government Chronicle Awards in London.

The project has helped more than 6,000 patients with cancer, heart disease, strokes, chronic obstructive pulmonary disease and cystic fibrosis access at least £17 million in additional benefits in the last two years.

By co-ordinating care, support and practical advice across a range of organisations in the city, the partnership has also allowed people to focus solely on their health and recovery when it matters most.

Employability
The Council's Supported Employment Service, funded by Social Work Services and the European Social Fund, was established in late 2009 to support people with learning disabilities into full time employment. From Feb 2010 to March 2012 the Service has supported 53 people with learning disabilities into full time employment. The Service has also achieved high sustainability rates with 82% of clients still in work after 6 months and 77% after one year.

The Bridging Service**,** managed by Glasgow Regeneration Agency, is a team of approximately 20 staff offering specialist support from within health and social work premises. The Bridging Service received 750 referrals from health and social work services in 2010/11.

The Council's Care Leavers Employment Service has developed a strong partnership with the Glasgow Commonwealth Apprenticeship Initiative. In 2011, this partnership helped to support 18 care leavers to access apprenticeships, a significant increase on previous years. In June 2011 this employment service accessed additional European Funding through Glasgow Works to develop a new service to support a further 20 care leavers to access apprenticeship opportunities up until June 2013.

Carers
Carers, politicians and stakeholders welcomed the launch of the new Glasgow City Carers Partnership in December 2011. This new partnership aims to prevent unpaid carers from reaching crisis point and provides a universal offer of information and advice for all carers in the city through its Carers Information booklet, Carers Information Line and the Self Assessment. The initiative is run by Glasgow City Council's Social Work Services, NHS Greater Glasgow and Clyde, and the voluntary sector. The service aims to help carers and reassure them that they are not alone from the moment that a loved one receives a diagnosis of a life-changing health condition.

Disabilities
The comprehensive redesign of the Council's Occupational Therapy service is almost complete and will ensure faster access to services for people with disabilities. NHS Greater Glasgow and Clyde has successfully merged community older people's teams, physical disability teams and hospital discharge teams into one construct to form Rehabilitation Teams in each of the three sectors. In Learning Disability, a board wide NHS Strategy Forum has been developed and is now undertaking a review of NHS learning disability services.

Personalisation
A major achievement, as well as an unprecedented shift in social care service delivery, has been the introduction of personalisation and self-directed support in the city. The implementation of this important strategy began in 2010 with learning

disability services, followed by the roll-out in physical disability and now mental health services. As shown in our Key Targets section, we are aiming for 3,000 service users to have an Outcomes-Based Support Plan in place for personalised services by the end of 2012/13.

Mental Health

Service Reviews: Over the last year, NHS Greater Glasgow and Clyde has initiated reviews of its mental health services to ensure that people have access to care and support that is delivered more consistently to an agreed service specification and quality standard. The mental health service review spans primary, community, specialist crisis and inpatient services, all aiming to ensure a balance of service provision that continues to support people to live as independently as possible within the community, with access to the right levels of specialist care when it is needed. The reviews of primary care mental health care services and crisis services have now been completed and work is commencing on their local implementation across the city. A key aspect of all the reviews is to ensure that we meet our efficiency savings target by ensuring our services are configured as efficiently and effectively as possible.

Promoting Mental Health and Well-Being: Many activities and initiatives have taken place aimed at promoting mental health and well being, ranging from the commissioning of voluntary sector provision through to actioning specific work programmes including suicide prevention, promoting employability and financial inclusion, reducing stigma and targeted health improvement work within specific communities. Specific examples include mental health-based programmes with black and ethnic minority communities, such as the Mosaics of Meaning programme and the Wah Kin Project, a focus on the mental health needs of the LGBT community (including commissioned research work: "There's More to Me") and a body of community-based suicide prevention activity aimed at disadvantaged communities in North and East Glasgow. The highly successful Scottish Mental Health Arts and Film Festival is now entering its 6th year, and there will be a diverse programme of activity across Glasgow for 2012, building on previous years' achievements. Work of this nature will continue to be a key focus in the year ahead, not least because of the anticipated additional demand for support as a consequence of the economic climate.

A recent self-evaluation study of Glasgow City Council's range of mental health community and supported living services found that Mental Health Services in Glasgow are impacting positively on service users and carers in the following areas:

- Service users generally reported that their needs were being met - this was supported through a file reading exercise from social work and provider files. Carers also reported feeling supported in their caring role by the services that they received.
- There was evidence that the commissioning team have worked in partnership with housing to identify high quality accommodation for mental health service users.
- There was evidence that people are moving on through supported accommodation services with many securing independent tenancies.

- The services highlighted good practice with regards to 'forensic' service users who are allocated supports based on need and not related to involvement with criminal justice.

Homelessness

There are strong and well established links across Social Work, Health, Housing and the Voluntary Sector which have contributed to the success of many initiatives to improve service provision to homelessness clients over a number of years. The following examples demonstrate the effectiveness of this approach:

Hostel Closure Programme: The Hostel Decommissioning and Reprovisioning Programme saw the closure of over 700 bed spaces across three large-scale, city-centre male hostels for the homeless. The programme represented a comprehensive shift in the city's approach to homelessness and developed an unprecedented approach to decommissioning hostels and reprovision of services, with a strong emphasis on service user consultation. Alongside the development of approximately 1700 units of temporary accommodation, over 600 places were provided in small scale supported accommodation services, plus outreach support and a range of health services provided through dedicated teams, leading to a transformation in how people affected by homelessness are supported within the city.

An independent longitudinal study into outcomes for ex-hostel residents of the programme was carried out by the Centre for Housing Studies at the University of York. The study highlighted the positive outcomes for ex-residents as a consequence of the closure programme. Significantly, all residents interviewed as part of the study felt that closing the hostels was the right thing to do and that they felt that it had been well resourced.

Women's Services: The development of an Integrated Service Model of accommodation and support for women experiencing homelessness in Glasgow was approved in August 2007, to assist with the closure of Inglefield Street hostel. The proposal included provision of a new, purpose built residential facility for up to 26 women, with one flat suitable for women with children. Occupation levels within Inglefield Street were gradually reduced as part of the closure plan, in advance of the opening of the new Chara Centre in July 2012. The Centre will provide temporary accommodation for homeless women, and offer a multi-disciplinary approach to assessment of their assistance, care and support needs.

Homelessness Services have also commissioned and reconfigured a number of purchased or directly provided services to provide gender specific emergency and resettlement accommodation and support options for women, in recognition of demand for such services. This programme has been achieved with significant support from Service Providers, Housing Associations, and staff within the Council, including Social Work Services and Development and Regeneration Services.

Reducing Repeat Homelessness: Section 11 of the Homelessness etc. (Scotland) Act 2003 came into force on 1 April 2009, requiring landlords and creditors to notify local authorities when taking court proceedings for repossession or calling in a mortgage. Through coordinated joint work across Social Work Services, NHSGGC and colleagues within the GAIN Network, vulnerable households are offered a

holistic response to support them to avoid losing their tenancy. Improved engagement with mainstream health services as part of resettlement and improved tenancy sustainment by contracted housing support providers has also contributed to the reduction in repeat homelessness.

As described on pages 17-19, the Plan is now structured by the five common objectives for Adult Services in the City.

Objective 1: Early prevention and harm reduction

Glasgow City Council and NHS Greater Glasgow and Clyde are committed to working with the broad spectrum of city partners to improve the overall health and well-being of the population of Glasgow. We will continue our efforts to promote positive health and well-being, early prevention and harm reduction, ensuring that people get the right level of advice and support to maintain independence and minimise the occasions when people engage with services at a point of crisis in their life.

Alcohol and Drugs
One of the main aims of the Alcohol and Drug Partnership is to create a consistent shared approach to delivering prevention activity throughout Glasgow, by building a strategic vision about what can be achieved collectively whilst Mental Health services aim to strengthen the interface with health improvement in the redesign of primary care mental health activities.

A review of all systems with regards early prevention is linked to the city wide prevention model while at the same time a prevention network is being set up to work in conjunction with this. The Network will look to support national alcohol and drug programs locally while also making recommendations on levels of harm. There has also been the continuation of the Ripple Effect research study to test whether citizens of Glasgow feel alcohol affects their community, and if so, to identify and examine these effects. Furthermore, the GRAND (Getting Real About Alcohol N Drugs) Week, created to raise awareness of drugs and alcohol issues and services, as well as encouraging Glasgow citizens to get involved in tackling these issues in their communities, will continue to take place in 2012.

We will also seek to ensure that when needs arise, our services focus on early assessment and intervention and seek to maximise opportunities for recovery and enablement. We will seek to support older people to remain active in later life, have meaningful things to do and be part of their local communities. We will use a co-ordinated approach with partners to strengthen support to vulnerable older people and reduce isolation though the One Glasgow pilot programme. A standardised joint approach to the assessment of older people's needs will be implemented. A single point through which older people's services can be accessed will be developed, whilst continuing to raise awareness and understanding of dementia and promoting early identification and improved response, including through the introduction of a primary care dementia screening programme.

Homelessness
In order to meet Scottish Government requirements regarding the Abolition of Priority need, the age parameters for acceptance of homelessness applications have been incrementally extended, and the Council has agreed that from 1st October 2012, all applicants who have been assessed as homeless will be deemed to have a priority need. Homelessness Services has reconstituted the Homelessness Duty Protocol Working Group, reflecting the commitment to work positively with colleagues across

the Registered Social Landlord network, to monitor and review the operation of the protocol, improve communication and knowledge of stock and turnover, and to secure an adequate supply of allocations to homeless households through the Section 5 process. Section 5 referrals are the formal means by which local authorities can ensure that homeless people are housed by registered social landlords.

A Project Board, including representation from Social Work, the NHS, housing associations and the voluntary sector, has been established to take forward a Housing Options Pilot due to commence in mid 2012 in the North West locality.

A tender has been issued for a new street service, targeted at people who have difficulty in engaging with services, and who may be in need of both housing and support services. The success of the Council response to winter pressures in 2011/12 is being evaluated and will be used to inform planning for next winter.

Carers

There is a commitment to real preventative interventions, and to putting in place measures which keep carers well, through the partnership of Social Work, the NHS and third sector community based expertise. As noted in the Achievements section, the Glasgow City Partnership Carers Pathway, launched in December 2011, established a universal offer of advice and information to all carers within Glasgow. This pathway seeks to identify carers early on in the caring pathway/at point of diagnosis within both primary care, acute and social care settings to ensure that carers have access to information, advice and supports in their caring role. The self-assessment is a point through which all carers can be screened to identify low-level supports required and those with the greatest need. There is also a need to work in partnership with the third sector to build community capacity to support carers through volunteering, peer support and other community responses.

Employability

Health and Social Work Services will continue to work in partnership with Glasgow Works, the strategic employability partnership, to develop specialist employability services to more effectively meet the needs of people who may have been long term unemployed and have significant barriers to overcome.

Learning Disability

NHS Greater Glasgow and Clyde is now reviewing its existing service model for people with Learning Disabilities and subsequently planning to introduce redesigned services. The new service model will be less reliant on inpatient beds, will ensure that the people who most need additional support will receive it, have a more positive experience, and recover more quickly. This model will comprise of hospital based acute admissions, community based assessment and treatment, and a longer stay service.

Mental Health

The ‘No Health without Mental Health’ recommendations will be taken forward as part of our mental health improvement programme, taking into account the likely increase in mental health issues arising from the wider economic situation.

We will also implement a comprehensive, multi-agency suicide prevention programme, led by Glasgow City "Choose Life" Strategy Group. A multi-agency action plan will be developed that includes actions to develop and implement a more co-ordinated approach to reduce suicidal behaviour, better support for those affected by suicidal behaviour, and maintaining the level of designated front line staff trained in suicide prevention skills. Agreed training priorities over the next year include children & families residential staff and homelessness case workers.

Other priorities for early prevention and harm reduction 2012/13 are to:

- Support the local implementation of the National Accommodation Strategy for Sex Offenders; Children's Services; Schools; NHS Children Service Managers and SW Children and Families services, to develop a systematic sharing of information on children affected by homelessness.

- Continue to monitor activity around provision of targeted advice and assistance to people notified to Homelessness Services as at risk of losing their homes, as a result of Section 11 of the Homelessness etc (Scotland) Act 2003, which places a duty on landlords and creditors to notify the Local Authority when they raise proceedings for repossession of a dwelling house. A system has been developed to provide a coordinated response across partner organisations.

- Maintain effective support, transfer and tenancy sustainment of homeless people with complex physical, mental health and substance misuse needs who are being resettled in local communities.

- Change the culture around alcohol and excessive drinking while at the same time looking to reduce both the availability and consumption of alcohol and drugs.

- Implement a number of projects supported by the Change Fund for Older People relating to the themes of 'Preventative and Anticipatory Care' and 'Proactive Care and Support at Home'.

- Develop joint working to develop plans to prevent depression and anxiety, and promote the positive physical and mental health and well-being of older people.

Objective 2: Providing greater self-determination and choice

A major shift in emphasis in the delivery of health and social care services over the past few years has been towards ensuring that service users and their carers are given the opportunity to make their own choices about how they will live their lives and what outcomes they wish to achieve.

Personalisation

As summarised earlier, Personalisation of social care is a national strategy that seeks to deliver social care and support in line with a vision of promoting independence and delivering positive outcomes. The aim of this policy is to deliver high quality care and support services for the people of Glasgow, now and in the future, by allowing people to choose the type of support they want, and to get the results they need.

Research has shown that Personalisation can lead to people benefiting greatly from having choice and control over their social care and support services. It has shown that this has a significantly positive effect on people's lives and has indicated that costs could be no more than that of traditional services. Furthermore, the Council believes that giving greater choice, control and independence to everyone who needs support is in principle the right thing to do. A personalised approach will lead to a more efficient and equitable distribution of available resources.

Advocacy

In late 2010 a joint Council-NHS review group met to look at the future joint arrangements for the provision of independent advocacy services in Glasgow. The review concluded that advocacy services have never been more critical to service users in Glasgow. The implementation of personalisation has increased the need for independent advocacy, which plays a vital part in safeguarding individuals in situations where they are vulnerable, supporting people to raise concerns about the services that they receive, seeking resolutions to service provision issues, and ensuring that they understand their civil and humans rights. A joint framework agreement has been developed and the Joint Partnership Board has approved proposals to re-tender independent advocacy services funded by a common budget. New contracts will be in place during 2012 following the tendering process, resulting in a service or services that can better support individuals who require representation in Glasgow.

Carers

The Carers Strategy 2008-11 will be revised and updated in consultation with key stakeholders including the Carers Reference Group. This will include a strategic vision for carers' services, which reflects choice, control and personalised approaches in service planning and delivery. It will ensure that carer services are person centred and take account of age, gender, race, religion and disability. A key priority will be for carers to have access to the right level of support when they need it. The engagement of carers will be central to this process.

Employability

All health and social work assessment processes (including the Self Evaluation Questionnaire relating to Self Directed Support) now include a section on 'employability aspirations', which allows the service user to choose whether they would like to find out more about their options for work, training, education or volunteering.

The Council and NHS Greater Glasgow and Clyde have worked in partnership with Glasgow Works to develop a number of new employability services which support specific groups. These services include a Supported Employment Service for people with learning disabilities, a service to support young people leaving care to access apprenticeship opportunities, and the 'Bridging Service', managed by Glasgow Regeneration Agency that is specifically funded to support people referred from health and social work services. The development of these new services provides people with a wider choice of service, which should more effectively meet their individual needs.

Alcohol and Drugs

The Alcohol and Drugs Partnership aims to ensure that all of our treatment services are able to offer the range of supports, which are required to integrate treatment and wider recovery, linked to ensuring the delivery of immediate and accessible services across the city, for people with alcohol and drug misuse problems. Furthermore the Partnership is determined to guarantee that all services are person centred and take account of age, gender, race, religion, disability and other protected characteristics.

To accomplish these objectives, the Partnership will make certain that recovery is aligned to rehabilitation options across the city; embed recovery within assessment treatment options and reflect recovery plans for each service user; and demonstrate an understanding of the role equalities has in positive recovery in order to ensure provision reflects the need to promote full engagement. This will be done by guaranteeing that all recovery plans will record protected characteristics. The Partnership will also ensure that all new developments will have had Equality Impact Assessments carried out prior to implementation and that service users are involved in decisions about their care and have control over all their own development opportunities.

Objective 3: Shifting the balance of care

Services have transformed over recent years to shift the balance of care away from institutional, hospital-led services towards services better able to support people in the community and promote recovery and greater independence wherever possible. The following chapter summarises the main activity to further shift the balance of care during 2012/13.

Mental Health

Glasgow City Council and NHS Greater Glasgow and Clyde will continue to review current community and inpatient provision for mental health services to ensure the balance is appropriate and is delivered in an efficient and sustainable way. Services will work together to establish joint commissioning arrangements that take account of both strategic objectives and the implementation of personalisation including a joint mental health service and financial framework, underpinned by an agreed pool of resources to shape service change and help inform future investment / disinvestment programmes.

Mental Health Services will progress and implement the outcome of the NHS-led primary and community adult mental health service reviews, delivering a more consistent and efficient service model across the city. Inpatient and crisis services are also being reviewed to deliver the optimum balance of care and efficient bed model, including progressing the reconfiguration of adult mental health beds currently at Parkhead, Stobhill and Ruchill hospitals.

Employability

The Bridging Service, managed by Glasgow Regeneration Agency, is a team of 20 staff who provide support to people referred from health or social work services in Glasgow to move into employment, training, education or volunteering. A recent survey involving a group of people referred from health and social work services has found that the Bridging Service helped to reduce the number of people reporting mental and physical health as barriers to employment. The study also reported an increase in overall wellbeing, a reduction in visits to the GP and 32% of participants either gave up or reduced their level of smoking.

A recent evaluation of the Council's Supported Employment Service for people with learning disabilities identified that individuals that moved into employment were on average £98 a week better off thus contributing to the financial independence of service users.

Carers

Shifting the balance of care will impact on carers and their caring role. If more older people are to remain in the community then resources will be needed to provide the services that carers most value such as time out from caring; training to support the caring role, e.g. on moving and handling or dementia awareness; income maximisation; emotional and practical support; and information and advice. We have a strong carer support infrastructure in Glasgow which includes third sector partners. We want to build on this to ensure that our aims for unpaid carers are realised.

Older People

We will be working with partners to redesign older people's services and shift the balance of care away from hospital and institutional care towards preventative and community based alternatives that enable people to be supported to live at home. We will continue to develop and update the Glasgow City Change Plan and implement a range of projects supported by the Change Fund which aim to support a shift in the balance of care. Another priority is to further develop and implement plans in order to reduce delayed discharges and the numbers of bed days lost to delays, including those for older people with incapacity. Furthermore, work will continue to ensure that services are in place that support people in the community and respond to their changing needs, which contribute to the aim of reducing unnecessary emergency admissions. See also the section on Reablement below.

Further details will be available following the production of the Joint Strategy for Older People for Glasgow, developed in partnership with the independent and voluntary sectors that will set out our aims for older people's services and the key changes that we will be progressing to achieve these.

Reablement

Implementation of the Reablement Service seeks to maximise people's existing self help skills and / or support people to re-learn skills lost due to illness or long term conditions. Reablement has currently been introduced in older people's services but it also fits with ongoing strategies to support adults with disabilities to maintain or develop the skills necessary to remain at home. This is likely to be implemented for people with disabilities from April 2014 to March 2015. Following implementation it is likely that there will be an increase in early discharge from hospital and a reduction in re- admission rates, with people feeling safer and confident in their ability to remain at home. It is anticipated that service users will also feel more involved in the design of their care package.

Homelessness

NHS Greater Glasgow and Clyde's Homelessness Health Services continue to review referral routes into health services with the aim of ensuring mainstream health support to medium and long term homeless accommodation providers. Homelessness services continually strive to secure an adequate supply of quality emergency, temporary and permanent accommodation to meet the needs of new and existing service users. Joint working protocols between Homelessness Health Services are regularly reviewed with emergency accommodation providers.

Alongside the Vulnerable Household Forums and Local Housing Forums, Homelessness lead officers continue to chair the local Essential Connections Forums to facilitate partnership working between health, social care and housing providers.

Alcohol and Drugs

The Alcohol and Drugs Partnership aims to achieve a shift in the balance of care mainly through the 'recovery and protecting vulnerable groups' aspects of its strategy. This is outlined through its objectives of delivering immediately accessible services across the city for people with alcohol and drug misuse problems, while also improving early intervention of vulnerability where an adult or child is dependant on

an individual who is misusing substances. A key aim is also to reduce the availability of both alcohol and drugs, linked to a reduction in their consumption.

The Partnership will achieve these objectives through the continuous improvement in identification, assessment, risk management, planning and multi-agency responses to improve outcomes. We will continue to develop methods to raise awareness to ensure parents, carers and communities protect the most vulnerable. In addition, there is an active program to encourage family members to be involved in the recovery program surrounding a relative with addiction issues; the Circles of Care program is an example of the Partnership's work in this area. The Partnership will, through the prevention network, look to consider and make recommendations on wider licensing issues. It is through the adoption of these methods that we will attain the working outcomes of ensuring that those people involved in a carer role feel supported and capable in their position, while at the same time service users will feel both physically and emotionally safe.

Objective 4: Enabling independent living for longer

The following section outlines the priority work that will be taking place across our Care Groups during 2012/13 that will assist people to continue to live healthy, meaningful lives as active members of their community for as long as possible.

Accessible Housing
Social Work Services aims to encourage and promote the provision of accessible and appropriate housing for adults with disabilities across Glasgow through discussions with Development and Regeneration Services, and agreement on input to Glasgow's Housing Strategy. The availability of a variety of housing options is equally important to all client groups. The shift in the provision of care from residential or institutional settings for people with disabilities to ordinary community based housing means that there needs to be a range of affordable and accessible housing available to support independent community based living. The implementation of personalisation and the reablement service described earlier will result in more people choosing to be accommodated and supported in the community and will increase the need for accessible housing. Key actions include:

- improvement of engagement at local level between social work, health and housing providers
- review and implementation of targets for provision of wheelchair accessible housing within new social housing development programmes
- making better use of existing resources, including existing accessible housing, aids and adaptations, and development of a Common Housing Register alongside work by Glasgow Council for Independent Living to develop a national register of disabled people
- consideration of models of sheltered housing and any changes which could help improve service delivery through current provision, as part of the broader reshaping care agenda
- continued prioritisation of housing investment for service users.

By 2012, 211 accessible units will have been developed across 10 local Housing Forum areas. The Common Housing Register will be established by the end of December 2012 and an analysis of existing housing stock and waiting lists for wheelchair accessible housing will have been completed. It is also anticipated that the delivery of planned adaptations across the city's housing stock will have been completed. The outcome of the review by the National Adaptations Working Group will be used to inform planning for the provision of adaptations across the city.

Occupational Therapy
Maintaining people in their homes and supporting them to access social, leisure, education, training and, where possible, employment opportunities, relies on getting the right level of support to the people who need it at the right time. Occupational therapy services play a huge part in supporting people to stay at home and to be active for as long as possible. The redesign of Glasgow City Council's Occupational Therapy Service is therefore a priority. The main aim for occupational therapy services is to support people with a wide range of needs to live at home

independently by providing rehabilitation services and improved access to a range of equipment and adaptation services.

Carers
If we are to enable independent living for longer then it is important that the carers' partnership works at strategic level to develop services for carers. Future service developments for carers need to develop beyond traditional support service delivery to individual carers, and seek to identify, develop and resource community capacity opportunities through volunteering, befriending and peer support programmes. There is a need to build on the services currently provided by both statutory and voluntary sectors, carers' centres, and condition specific organisations funded from within existing Council and Health Board resources, and through the jointly managed Change Fund for older people.

Older People
We will seek to ensure that services are in place that enable older people to live independently in their own homes, or in suitable community based alternatives, for as along as it is appropriate and safe for them to do so. Key actions include:

- implementing a number of projects supported by the Change Fund including the implementation of the reablement home care programme, the anticipatory care project, and the testing of models of intermediate care
- considering the implications of the personalisation agenda for older people
- working with housing and care providers to ensure that a range of suitable housing and support services are in place for older people
- extending the use of new technology which supports people to live independently in the community e.g. telehealth and telecare systems
- developing and improving the range and quality of support available in the community for people with dementia.

People with Acquired Brain Injury or Sensory Impairment
Work to facilitate effective service responses to meet the needs of people with acquired brain injury and those with sensory impairment is underway. The Council is committed to supporting people with complex support needs to remain at home for as long as is possible. The development of a new strategic plan for sensory impairment will be undertaken; priority actions within the Council's Acquired Brain Injury Strategic Framework will be refreshed and implemented.

Mental Health
Mental Health Services will continue to develop a recovery focus, which reduces dependency and enables individuals to live well in the presence or absence of illness, with an emphasis on rehabilitation and move-on to more independent living. This includes work to increase access to employability opportunities including paid employment for people with mental health issues through collaborative working with a range of voluntary and statutory organisations. Priorities include:

- joint development and implementation of a rehabilitation and care pathway
- ensuring the needs of people with mental health problems are reflected in the Local Housing Strategy and Housing Investment Plan

- piloting an employability assessment tool in the south of the City, with a view to it being rolled out to other employability services
- working in partnership with Glasgow Works to further develop the Employability Bridging Service across Glasgow
- working with services to increase referrals to mental health employability funded services, as well progressing partnership working with Jobcentre Plus and regeneration agencies.

Alcohol and Drugs

The Alcohol and Drugs Partnership recognises and supports the idea of promoting service users' independent living. It will firstly offer service users appropriate recovery opportunities linked to longer-term training, employment and social re-integration and, secondly, support alcohol and drug users to access universal Council and other services to support changes in lifestyles towards recovery. Finally, the Partnership is also looking to address the needs of drunk and incapable people in the community through the delivery of a number of joint alcohol initiatives.

In order to achieve these objectives, the Partnership will:

- support a citywide recovery network that will continue to improve and promote joint working between community forums and family support groups
- help service users explore employment opportunities while also enhancing volunteering through recovery
- assist with 'conversation recovery café's' throughout the city
- support the delivery of joint alcohol initiatives (e.g. the city centre SOS bus) which not only support drunk and incapable individuals, but help assault victims, people in emotional distress and those fleeing from domestic abuse.

Through these initiatives, the Alcohol and Drugs Partnership is ensuring that service users are engaged in both community leisure and social activities of their choice, while also creating opportunities within employment; education; training or volunteering and at the same time increasing service users' emotional and physical safety.

Objective 5: Quality care management

The following section outlines how the Council and the NHS Board intend to collectively promote a caring environment for service users and patients through the provision of high standards of organisational and professional practice which are conducive to maximising positive outcomes for each individual we support.

Mental Health
Quality care management and quality service provision are at the heart of improving service users' experiences. Our priorities for 2012/13 across a variety of areas include:-

- the introduction of robust systems to support the implementation and monitoring of personalisation and SDS, including robust assessment, care management and resource allocation arrangements
- the development of pathways and measurement criteria for ensuring timely access to psychological therapies
- the continuation of work with GPs to ensure anti-depressant prescribing in is line with good practice and to explore potential alternatives
- an improvement in the interfaces within addiction services, particularly around the transition of patients between services
- promotion of user and carer involvement in care planning, evidenced through outcomes measurement, local engagement groups, and carers' assessments
- improvement in multidisciplinary working when planning discharge from hospital for people with complex needs and physical impairment
- re-state the key priority for people to have access to the right level of care and support when they need it.

Young People in Transition
Transition arrangements for young people with disabilities are under scrutiny and the current transition protocol requires to be updated to take account of personalisation. Further work to improve planning and joint working across all services is planned, and a protocol will be developed to ensure that care management arrangements are in place for every young person in transition. This will result in a smoother, more seamless transition from children's to adult services with service users feeling more involved in the development of their care package and experiencing more opportunities for social leisure and employment opportunities.

To achieve this, we will:

- monitor/develop robust service transition arrangements for young people with a disability
- update and refresh a transition protocol that takes account of personalisation
- improve planning and joint working across all services, including greater liaison with housing, leisure, education and employment services
- develop a protocol that will ensure care management arrangements are in place for every young person in transition.

Homelessness

The NHS Greater Glasgow and Clyde Homelessness Health Services, including the integrated Homeless Addiction Team, continue to review their services in line with delivering quality care management for homeless people with complex needs. The reduction of the specialist service responds to the principles identified within the Homelessness Strategy to improve mainstream health service responses to homeless people. Service redesign and workforce planning has continually focused on improving the quality and efficiency of services while reducing resources to fit the level of need.

Homelessness Health Services will ensure that:

- an equality perspective is embedded in planning, policy and practice
- there is better understanding of women's issues and a greater focus to support women to develop skills which enable them to make positive progression and be able to maintain a tenancy
- increase knowledge on issues relating to women affected by trauma and homelessness, personal safety, self harm and domestic violence.

Homelessness Services within Social Work will continue to develop strategic liaison across Care Groups, both centrally and on a locality basis to promote integration of the homelessness agenda across all services, and to ensure continuity of care and care management through periods of transition, and encouraging movement from homelessness based to community based services through a period of resettlement.

Accommodation

Social Work Services has identified support projects where accommodation is not fit for purpose, and prioritised areas for investment through the housing association funding programme. This information has been detailed in the Social Care Housing Investment Priorities (SCHIP) report 2012-17, and progress against this report will be monitored by each Care Group. The Glasgow Housing Strategy confirms that SCHIP report, and developments which support the provision of community based services through the personalisation agenda, will be given priority within the new build programme.

Alcohol and Drugs

The Alcohol and Drugs Partnership will build the capacity of services to identify the needs of vulnerable groups affected by alcohol and drug use. Added to this it will improve responses and outcomes for vulnerable service users affected by drug or alcohol use, while also enhancing practice, assessment and risk management for all these service users. We will also develop performance-monitoring tools to scrutinise practice and outcomes.

The Partnership proposes to achieve the objectives connected with quality care management by firstly incorporating both Social work and NHS processes into alcohol and drug guidance. Added to this there will also be a full review of drug and alcohol services across the city. Furthermore, a thorough training and development program for staff is currently being carried out and we will continually improve through self-evaluation. An illustration of this is that knowledge gained from critical incidents is immediately integrated into learning practice.

Employability

NHS Greater Glasgow and Clyde and Social Work Services have prioritised the employability agenda in recent years and made a number of developments to support services users to access employability support. Assessment processes now require a discussion around the employability aspirations of service users. In addition, care managers have a good understanding of the employability services available if people do wish to find out more about their options for work, training, education or volunteering. Work has also taken place to develop the capacity of mainstream employability services to more effectively support vulnerable groups. These developments have helped to support an increase in the number of service users engaged with education, training and employability services.

In relation to future developments, we will continue to ensure that all service users are asked about their interest in work, training, education or volunteering at an appropriate point in the assessment process. We will also:

- monitor and manage delivery of employability targets including appropriate care group specific employability targets within Planning and Implementation Groups' Action Plans and / or Performance Frameworks
- ensure that workers across care groups have a good understanding of the employability support available to their clients / patients.

Carers

All key stakeholders in Glasgow have signed up to the partnership model and this is being driven strategically by the Carers Planning and Implementation Group which includes representation from carers themselves. At a local level, 'Joining up the Dots' events are taking place to bring together all stakeholders to ensure that the resources at a local level are deployed to ensure maximum impact to support carers, duplication is reduced and that we are making best use of available expertise and resources. Carers will complete the self-assessment booklet and their needs will be assessed and support identified. Statutory carers' assessments will be offered as required.

The role of carers is recognised as being of key importance and Glasgow City will increase the number of carers' assessments undertaken. Whilst acknowledging the importance of carers' assessments, the partners understand that achieving the outcomes identified in these is critical in enabling carers to continue caring. The latest performance information from Social Work Services shows that 342 carers were assessed within the two in-house services from April – December 2011, with the self assessment being the main point of entry for carers. Data from the voluntary sector carers' centres and condition specific organisations will be included in future performance reports.

Service Access and User Involvement

We will seek to ensure that people get access to the right level of quality care and support when they need it, and that we appropriately involve people and seek their views on the services we provide. Key actions include:

- ensuring involvement and engagement opportunities are in place for staff, users, carers and the wider community in relation to the Change Fund and

Joint Strategy for Older People, and assessment, planning and delivery of services

- implementing the Health Board's quality improvement programme for older people to improve patients' experience of NHS care

- reviewing services provided to care homes and ensuring older people are supported effectively within these and not admitted to hospitals inappropriately

- further embedding the 'Talking Points' user-defined outcomes framework into the assessment and care management processes for Self-Directed Support

- continuing to utilise all service user engagement fora across the City.

KEY PERFORMANCE TARGETS FOR 2012/13

Personalisation (Learning Disability, Physical Disability, Mental Health)
2,500 people will have and Outcome Based Support Plan (OBSPs) in place for personalised services
At least 15 % of these service users will take their support in the form of a Direct Payment
All service users with personalised services will receive a care review within 12 months
At least 95% of these service users will report feeling emotionally & physically safe at their review
At least 65% of these service users will report satisfaction with their involvement in their care (choices, support & information) at their review
At least 65% of service users will report satisfaction with opportunities for community involvement (social & leisure) at their review
Over half (51%) of service users will report satisfaction with opportunities for development (education, training & employment) at their review
Reablement
At least 75% of service users will report satisfaction on completion of the Reablement service
Reshaping Care for Older People
Twice as many older people will receive care at home than in residential accommodation
No-one will remain in acute hospitals for 6 weeks or more after being assessed as ready for discharge *All older people in residential accommodation will receive a care review within 12 months* *At least 85% of older people receiving care at home will receive a care review within 12 months*
Carers
Up to 700 Carer Assessments will be undertaken
At least 65% of carers will report feeling capable to continue in their role as a carer
Adult Support & Protection
At least 90% of Duty to Enquiries will be completed within 5 working days
At least 90% of ASP Investigations will be completed within 10 working days
All ASP reviews will take place within 3 months
Alcohol and Drugs
All service users will have a recovery plan in place
At least 90% of individuals will receive appropriate drug/alcohol treatment that supports their recovery within 21 days (also a HEAT target)
Employability
Upwards of 2,500 Social Work service users will be engaged with Employability Services
Homelessness
No more than 7,000 households will be assessed as homeless or potentially homeless *No more than 300 households will be reassessed as homeless or potentially homeless within 12 months*

SELECTED ADULT HEAT TARGETS AND STANDARDS FOR 2012/13

NHS HEAT TARGET 2012/13
At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation by March 2015 so as to ensure improvements in breast feeding rates and other important health behaviours.
NHS Scotland to deliver universal smoking cessation services to achieve at least 80,000 successful quits (at one month post quit) including 48,000 in the 40% most deprived within-Board SIMD areas over the three years ending March 2014.
Reduce suicide rate between 2002 and 2013 by 20%
Deliver faster access to mental health services by delivering 18 weeks referral to treatment for Psychological Therapies from December 2014.
By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.
No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013; followed by a 14 day maximum wait from April 2015.
HEAT STANDARD 2012/13
Provide 48 hour access or advance booking to an appropriate member of the GP Practice Team
NHS Boards and Alcohol and Drug Partnerships (ADPs) will sustain and embed alcohol brief interventions (ABI) in the three established settings (primary care, A&E, Antenatal). In addition, they will continue to develop delivery of alcohol brief interventions in wider settings.